



Claim No.:

Date of Incident:

**LISA MADIGAN**  
Attorney General - State of Illinois  
Crime Victims Compensation Bureau

## **FUNERAL DIRECTOR'S REPORT - ("D")**

***PLEASE COMPLETE BOTH SIDES OF THIS REPORT. THIS DOCUMENT IS TO BE  
FILLED OUT AND SIGNED BY THE FUNERAL DIRECTOR.  
RETURN TO THE ATTORNEY GENERAL'S OFFICE.***

Victim's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Claimant's Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Claimant's Address: \_\_\_\_\_

Street

City

State

Zip

<u>Person(s) who paid funeral / burial expenses:</u>	<u>Amount Paid</u>	<u>Relationship(s) to Victim:</u>
	\$	
	\$	
	\$	

Date of Death: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Cost of Burial: \$ \_\_\_\_\_ Cost of Funeral: \$ \_\_\_\_\_

Source and amount of reimbursements received / anticipated: (Insurance, Public Aid, etc.)

\_\_\_\_\_  
\_\_\_\_\_  
*Please Note: A person who the Court of Claims finds has willfully misstated or omitted facts relevant to the determination of whether compensation is due under this Act or of the amount of that compensation, shall be denied compensation under this Act and be guilty of a Class A misdemeanor.*

*Under penalties of perjury, I declare that to the best of my knowledge, all of my answers are true, correct and complete.*

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Month Day Year

Name of Funeral Director: \_\_\_\_\_  
(Please print or type.)

Signature of Funeral Director: \_\_\_\_\_

Address of Funeral Director: \_\_\_\_\_  
Street

\_\_\_\_\_  
City State Zip Code

Telephone # \_\_\_\_\_ FEIN (Tax ID) #: \_\_\_\_\_

RETURN TO:

LISA MADIGAN, ATTORNEY GENERAL  
CRIME VICTIMS COMPENSATION BUREAU  
100 West Randolph Street - 13th Floor  
Chicago, Illinois 60601

Contact (312) 814-2581 if you have any questions or need assistance.